PERSONAL INJURY QUESTIONNAIRE

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The following information will be needed by **The Reynolds Law Firm, LLC** in order to properly advise you and handle your case. Please print and fill out every applicable question. If a question is not applicable, please write N/A in the space. DO NOT LEAVE BLANKS. This information will help us help you. **THIS INFORMATION WILL BE KEPT CONFIDENTIAL**.

Date: _____

HOW DID YOU HEAR ABOUT THIS OFFICE: _____

I. Your Background Information

Full legal name: _____

Address: _____

Home phone: _____ Email address: _____

Birthdate: _____ Birth place: _____

Soc. Sec. No.: _____ Driver's Lic. No.: _____

Cell phone: _____

II. Your Employment Information

Employer: _____

Work Address: _____

Work phone: _____ Work Hours: _____

Rate of Pay: _____ (Provide gross annual rate of pay)

Have you lost any time for work, if so please state the dates and number of yours lost from work due to your injuries and medical appointments:

_____

_____

III. Collision Facts

Date: _____ Day of week: _____

Time: _____

Weather Conditions: _____

Location: _____

Describe how the accident happened:

_____

_____

_____

_____

_____

_____

Draw a diagram of the accident scene:

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IV. Your Vehicle, Medical Insurance Benefits, and/or Coverage:

Driver's name, address, phone:

_____

Owner(s)' name, address, phone:

_____

Passenger(s)' name, address, phone:

_____

_____

_____

Your Insurance Carrier: _____

Vehicle's Automobile Insurance Co., address, phone (if different):

_____

Policy No.: _____

Claim No.: _____

Date collision reported: _____

Coverage — liability limits, UIM (Uninsured Motorist) Limits: _____

PIP (Personal Injury Protection) or Med Pay: _____

Property Damage Adjuster — name, address, phone:

_____

PIP / Bodily Injury Adjuster — name, address, phone:

_____

UIM Adjuster / Underinsured Adjuster — name, address, phone:

Your Health Insurance Co. – name, address, phone:

Policy No.: _____ Group No.: _____

Have you attended an insurance medical exam? If so, please provide the name, address and phone of examiner and a description of what he or she did and said during the exam.

V. Defendant's (the other party) Information:

Driver's name, address, phone:

Owner(s)' name, address, phone:

Passenger(s)' name, address, phone:

VI. Defendant's (the other party) Insurance:

Automobile Insurance Co. - name, address, phone:

_____

Policy No. _____ Claim No. _____
Adjuster'sname, address, phone:

_____

Was your recorded statement taken? If so, by whom, when and were you provided a copy of the same. _____

Did you provide a written statement and if so when? _____

Do you have a copy of the written statement? _____

Did you sign a medical release for anyone? _____

VII. Witnesses:

Did the police or other law enforcement come to the accident scene or conduc an investigation? _____

Identify the investigating department (State Patrol, City Police, Sheriff):

_____

Police report number: _____

Was anyone ticketed? If so, by whom and for what: _____

Were any photographs taken? If so, by whom: _____

Identify any medics/fire departments: _____

Eyewitness - name, address, phone:

_____

_____

_____

VIII. Your Current Injury:

What part's of your body was injured in the accident?

_____

What part's of your body still cause you discomfort?

_____

Describe in detail all injuries from the collision:

_____

_____

_____

_____

Were you examined at a hospital — name, address, date(s):

_____

_____

List all health care providers who treated you for injuries from the collision — name, address, date(s):

_____

_____

_____

_____

_____

_____

Do you have any medical bills? Please provide copies: _____

Do you have any medical records? Please provide copies: _____

Any photographs, videotapes, etc. of your injuries, if so please provide copies: _____

Any diaries or notes concerning your injuries, if so please provide copies: _____

IX. Pre-existing Medical Conditions:

Have ever been treated by any health care provider for any pre-existing condition to the same body parts that were injured in this accident? If so please state the name, address and dates of treatment for each health care providers who treated you for injuries for the pre-existing condition - name, address, date(s):

_____

_____

_____

List all previous medical conditions — nature and dates (not referenced above):

_____

_____

List all health care providers who treated you for these prior medical conditions prior to the collision:

_____

_____

XI. Prior Suits & Claims:

List all prior insurance claims regarding any type of automobile accidents, boating accidents, worker's compensation claims and/or homeowner's claims including the nature, circumstances and dates:

_____

_____

List all prior law suits — nature, circumstances and dates:

_____

_____